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7  
8 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2008-290

12 RUTH ANNETTE CROWELL-BELL  
23613 Greer Road  
Murrieta, CA 92562  
13 Registered Nurse License No. 410496

**A C C U S A T I O N**

14 Respondent.

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16 Complainant alleges:

17 **PARTIES**

18 1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation  
19 solely in her official capacity as the Executive Officer of the Board of Registered Nursing,  
20 Department of Consumer Affairs.

21 2. On or about March 31, 1987, the Board of Registered Nursing issued  
22 Registered Nurse License Number 410496 to Ruth Annette Crowell-Bell (Respondent). The  
23 Registered Nurse License was in full force and effect at all times relevant to the charges brought  
24 herein and will expire on October 31, 2008, unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board of Registered Nursing  
27 (Board), Department of Consumer Affairs, under the authority of the following laws. All section  
28 references are to the Business and Professions Code unless otherwise indicated.

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1 physicians and registered nurses. These organized health care systems include, but are not  
2 limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of  
3 Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and  
4 public or community health services.

5 (b) The practice of nursing within the meaning of this chapter [the Nursing  
6 Practice Act] means those functions, including basic health care, that help people cope with  
7 difficulties in daily living that are associated with their actual or potential health or illness  
8 problems or the treatment thereof, and that require a substantial amount of scientific knowledge  
9 or technical skill, including all of the following:

10 (1) Direct and indirect patient care services that ensure the safety, comfort,  
11 personal hygiene, and protection of patients; and the performance of disease prevention and  
12 restorative measures.

13 (2) Direct and indirect patient care services, including, but not limited to, the  
14 administration of medications and therapeutic agents, necessary to implement a treatment,  
15 disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a  
16 physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health  
17 and Safety Code.

18 (3) The performance of skin tests, immunization techniques, and the withdrawal  
19 of human blood from veins and arteries.

20 (4) Observation of signs and symptoms of illness, reactions to treatment, general  
21 behavior, or general physical condition, and (A) determination of whether the signs, symptoms,  
22 reactions, behavior, or general appearance exhibit abnormal characteristics, and (B)  
23 implementation, based on observed abnormalities, of appropriate reporting, or referral, or  
24 standardized procedures, or changes in treatment regimen in accordance with standardized  
25 procedures, or the initiation of emergency procedures.

26 (c) 'Standardized procedures,' as used in this section, means either of the  
27 following:

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1 (1) Policies and protocols developed by a health facility licensed pursuant to  
2 Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through  
3 collaboration among administrators and health professionals including physicians and nurses.

4 (2) Policies and protocols developed through collaboration among administrators  
5 and health professionals, including physicians and nurses, by an organized health care system  
6 which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of  
7 Division 2 of the Health and Safety Code.

8 The policies and protocols shall be subject to any guidelines for standardized  
9 procedures that the Division of Licensing of the Medical Board of California and the Board of  
10 Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be  
11 administered by the Board of Registered Nursing. . . ."

12 8. California Code of Regulations, title 16, section 1442, states:

13 "As used in Section 2761 of the code, 'gross negligence' includes an extreme  
14 departure from the standard of care which, under similar circumstances, would have ordinarily  
15 been exercised by a competent registered nurse. Such an extreme departure means the repeated  
16 failure to provide nursing care as required or failure to provide care or to exercise ordinary  
17 precaution in a single situation which the nurse knew, or should have known, could have  
18 jeopardized the client's health or life."

19 9. California Code of Regulations, title 16, section 1443, states:

20 "As used in Section 2761 of the code, 'incompetence' means the lack of possession  
21 of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed  
22 and exercised by a competent registered nurse as described in Section 1443.5."

23 10. California Code of Regulations, title 16, section 1443.5 states:

24 "A registered nurse shall be considered to be competent when he/she consistently  
25 demonstrates the ability to transfer scientific knowledge from social, biological and physical  
26 sciences in applying the nursing process, as follows:

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1 (1) Formulates a nursing diagnosis through observation of the client's physical  
2 condition and behavior, and through interpretation of information obtained from the client and  
3 others, including the health team.

4 . . .

5 (5) Evaluates the effectiveness of the care plan through observation of the client's  
6 physical condition and behavior, signs and symptoms of illness, and reactions to treatment and  
7 through communication with the client and health team members, and modifies the plan as  
8 needed. . . .”

### 9 COST RECOVERY

10 11. Section 125.3 of the Code provides, in pertinent part, that the Board may  
11 request the administrative law judge to direct a licensee found to have committed a violation or  
12 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation  
13 and enforcement of the case.

### 14 STATEMENT OF FACTS

15 12. On or about November 13, 2004, Patient S.S. (MR # 239-20-77), a 47 year  
16 old female, was admitted to the Martin Luther King, Jr. / Charles R. Drew Medical Center (King  
17 / Drew) emergency room. Patient S.S. complained of shortness of breath, dizziness, palpitations  
18 and “feeling sick” for the day. Patient S.S. was diagnosed with “severe community acquired  
19 pneumonia” and admitted to the step-down unit for treatment. After admission, Patient S.S.’s  
20 respiratory status became progressively worse requiring endotracheal intubation on November  
21 14, 2004. Patient S.S. had a “bacteremia” and was additionally diagnosed with sepsis and Adult  
22 Respiratory Distress Syndrome.

23 13. On or about November 14, 2004, Patient S.S. was transferred to the  
24 Intensive Care Unit (ICU) in “guarded condition.”

25 14. On or about November 18, 2004, Respondent was employed as a  
26 registered nurse at King / Drew in Los Angeles, California. Respondent was assigned to the ICU  
27 unit and worked a 7:00 a.m. to 7:30 p.m. shift. At approximately 7:00 a.m. on November 18,  
28 2004, Respondent was assigned to provide nursing care to Patient S.S.

1                   15.     The ICU unit was adequately staffed to meet patient care needs on  
2 November 18, 2004.

3                   16.     Due to low levels of hemoglobin and hematocrit noted for Patient S.S. on  
4 November 17<sup>th</sup>, packed red blood cells were ordered for Patient S.S. on the morning of  
5 November 18, 2004. Respondent did not notify the physician and / or document in the patient's  
6 records her concerns with possible problems due to the need for a central line and with  
7 administering the blood in light of the patient's elevated temperatures throughout the day of  
8 November 18<sup>th</sup>. Respondent did not begin administering the packed red blood cells to the patient  
9 until after 5:00 p.m. on November 18, 2004.

10                  17.     Patient S.S. had a peripheral intravenous line and an arterial line which  
11 gave a continuous blood pressure reading on a monitor. Throughout Respondent's shift on  
12 November 18, 2004, Patient S.S. had periods of elevated blood pressure. Records from the blood  
13 pressure monitor indicated a discrepancy between arterial and cuff blood pressure readings.  
14 Despite the fact that the patient had no past history of elevated blood pressure and was not  
15 receiving any medication for high blood pressure, Respondent did not document and / or notify  
16 the physician of the elevated blood pressure readings or the discrepancy in monitor and cuff  
17 blood pressure readings.

18                  18.     The standard of care for ICUs require a complete nursing assessment to  
19 take place on each patient at least once every four hours. Respondent only performed and  
20 documented a complete assessment of Patient S.S. at 8:00 a.m. on November 18, 2004. A partial  
21 assessment was performed and documented at 12:00 p.m.. No assessment was performed on  
22 Patient S.S., or documented at either 4:00 p.m. or at about 5:02 p.m., when the patient became  
23 agitated and pulled out her NG tube and experienced a decline in blood pressure.

24                  19.     Respondent did not document and / or check urine output on Patient S.S.  
25 to ensure the patient was adequately hydrated.

26                  20.     At about 5:00 p.m. on November 18, 2004, Patient S.S. became agitated  
27 and began pulling at her tubes. Respondent noted "no acute changes" in the patient's chart and  
28 medication was given to calm Patient S.S.

1                   21.     A change in Patient S.S.'s heart rate and drop in blood pressure was noted  
2 by Respondent at 5:35 p.m. Respondent did not call a "code blue" on Patient S.S. at 5:49 p.m.  
3 Respondent did not administer atropine to Patient S.S. until 5:50 p.m. Advanced cardiac life  
4 support was administered, but Patient S.S. expired at 6:44 p.m. The subsequent autopsy report  
5 listed the cause of Patient S.S.'s death as, "Adult Respiratory Distress Syndrome with Pneumonia  
6 (under therapy), exact organism not established." The autopsy report listed anemia as a  
7 contributing factor in the patient's death.

8                                   **FIRST CAUSE FOR DISCIPLINE**

9                   **(Unprofessional Conduct - Incompetence, Negligence and/or Gross Negligence)**

10                   22.     Respondent is subject to disciplinary action under section 2761,  
11 subdivision (a)(1), on the grounds of unprofessional conduct in that Respondent's conduct was  
12 incompetent and / or grossly negligent within the meaning of California Code of Regulations,  
13 title 16, sections 1442 and 1443, and as defined in California Code of Regulations, title 16,  
14 section 1443.5, in that while employed as a registered nurse at King / Drew, Respondent failed to  
15 provide care or exercise ordinary caution, which she knew or should have known could  
16 jeopardize the patient's health or life as follows:

17                   a.       On or about November 18, 2004, Respondent received a physician's order  
18 to administer packed red blood cells to Patient S.S. Respondent failed to notify the physician and  
19 / or document in the patient's records her concerns with possible problems in administering the  
20 blood due to the need for a central line and the fact that the patient had elevated temperatures  
21 through out the day. Respondent failed to administer the packed red blood cells to the patient  
22 until after 5:00 p.m. on November 18, 2004.

23                   b.       On or about November 18, 2004, Respondent failed to properly work with  
24 the physician, and other health team members, to develop a plan of care to safely administer  
25 blood to Patient S.S..

26                   c.       On or about November 18, 2004, Respondent failed to notify the  
27 physician and / or document in the patients records that Patient S.S. had elevated blood pressures  
28 and that there were discrepancies in the patient's monitor and cuff blood pressure readings.

1 d. On or about November 18, 2004, Respondent failed to perform complete  
2 assessments of Patient S.S. as required every four hours and following changes in the patient's  
3 condition.

4 e. On or about November 18, 2004, Respondent failed to document and / or  
5 check urine output on Patient S.S. to ensure the patient was adequately hydrated.

6 **SECOND CAUSE FOR DISCIPLINE**

7 **(Violation of Statutes and Regulations / Failure to Perform Assessment)**

8 23. Respondent is subject to disciplinary action under section 2761,  
9 subdivision (d), on the grounds that Respondent violated the requirements of Section 2725,  
10 subdivision (b)(4) and California Code of Regulations, title 16, section 1443.5, subdivision (1),  
11 in that Respondent failed to properly formulate a nursing diagnosis of Patient S.S., through  
12 observation of the patient's physical condition and behavior, as more fully set forth in paragraph  
13 22, above.

14 **THIRD CAUSE FOR DISCIPLINE**

15 **(Violation of Statutes and Regulations / Failure to Evaluate and Modify Care Plan)**

16 24. Respondent is subject to disciplinary action under section 2761,  
17 subdivision (d), on the grounds that Respondent violated the requirements of Section 2725,  
18 subdivision (b)(4) and California Code of Regulations, title 16, section 1443.5, subdivision (5),  
19 in that Respondent failed to properly evaluate the effectiveness of Patient S.S.'s care plan and  
20 modify the plan as needed, as more fully set forth in paragraph 22, above.

21 **PRAYER**

22 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
23 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

24 1. Revoking or suspending Registered Nurse License Number 410496, issued  
25 to Ruth Annette Crowell-Bell;

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2. Ordering Ruth Annette Crowell-Bell to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;
3. Taking such other and further action as deemed necessary and proper.

DATED: 4/20/08

  
RUTH ANN TERRY, M.P.H., R.N.  
Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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